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ABSTRACT

This paper describes the development of a program which uses paraprofessional home visitors, known as Child Development Trainers, as disseminators of information necessary for the growth and development of the fetus and young infant. These Trainers serve a low income population. Weekly home visits were designed to aid the expectant mother to understand nutritional needs and prepare for the arrival of her new infant. Difficulties of recruiting and convincing families are discussed, and the advantages of using the paraprofessional are explored. Data include pre- and postnatal dietary records of mothers and children which document the need for more attention to nutrition in low income families. Weekly reports of paraprofessionals were condensed and presented to show demographic data, parental participation, maternal attitudes, and changes in these attitudes over time. [Not available in hard copy due to marginal legibility of original document.] (Author/DM)

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Prenatal-Postnatal Intervention: A Description and Discussion of Preliminary Findings of a Home Visit Program Supplying Cognitive, Nutritional and Health Information to Disadvantaged Homes.[1]

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SUMMARY

This paper describes the development of a program which uses paraprofessional home visitors, who are designated as Child Development Trainers, as disseminators of information necessary for the growth and development of the fetus and young infant. The low income population served is similar to the one described by Eleanor Pavenstadt in "The Drifters." Weekly home visits were designed to aid the expectant mother to understand her own nutritional needs and to prepare for the arrival of her new infant. The difficulties of recruiting and convincing families who have had less than satisfactory associations with other community agencies is discussed, and the unique advantages of using the paraprofessional for this type of home visit work will be explored. Data presented will include dietary records of both mothers and children before and after birth of the child. Such records document specifically the need for more systematic attention to the nutritional needs of the low income mother and child on the part of community agencies providing services for families. Weekly reports submitted by the paraprofessionals were condensed and presented to provide various demographic descriptions. The paraprofessional reports on parental participation in infant learning interactions were presented to index maternal attitudes toward such participation in infant learning experiences and to monitor changes in these attitudes with time. (A brief explanation of the cognitive, nutritional and health programs will be presented and selected anecdotal records will illustrate the reaction of different families to this program.)

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In September of 1969, ten women were hired by the Syracuse University Children's Center to assume the paraprofessional role of Child Development Trainer, (CDT). These women came from a variety of backgrounds and experience, but a common denominator in most cases was living experience in the neighborhoods in which they would be working.

The methods and philosophy of selecting and training paraprofessionals expressed by Lally in Gordon's (1969) final report to the Children's Bureau were followed. The program began with an eight-week training session, during which time the women were trained in nutrition, health, interviewing techniques, and early cognitive input to infants. The CDT's received instruction from dietitians, child psychologists, sociologists, nurses, and teachers, each of whom demonstrated skills from their own fields which were necessary for the successful functioning of a future home visitor. In addition to lectures and talks, the CDT's participated in practice and role-playing sessions which gave them practical experience in the skills they would be using, as well as some experience with problems which might arise when they were actually in the homes. The CDT's also spent many hours as teacher's aides in the various classrooms of the nursery school in order to obtain first-hand experience in dealing with the young child.

The CDT's moved into their home visit program slowly. They began with only one or two cases which were either expectant mothers or mothers of six-month-old babies who had entered the nursery school program. Gradually, the case load increased to the limit of twenty families per CDT. The entire operation of the home visit program is based on one assumption. This assumption is that each of the families visited wants everything possible for their child, and that they are willing to provide it if they know what needs to be done.

THE SAMPLE

The names of the mothers who participated in the program were drawn from various sources. In order to obtain the names of expectant mothers, hospital clinics were contacted in the Syracuse area. The names of those mothers who were pregnant for the first or second time were given to a member of our staff, so that we could contact and discuss our project with them.

The birth records of Onondaga County were surveyed by a staff member, and the names of those mothers who fit our criteria were noted. Another source of names was the YMED (Young Mothers in Education) Program. They provided us with the names of young, unwed mothers who planned to keep their children

The sample consisted of families in which the mothers were without a high school education, or a skilled occupation. The family income was less than $5,000 a year. If the father was living in the home he had to have a high school education or less. The study child was either the first or second born, and if he was a six month old entrant into the nursery part of the program, strict medical restrictions were observed. Children were accepted who: 1) weighed more than 4 pounds, 10 ounces, 2) had no respiratory problems, 3) were single births, 4) were not born by cesarean section, 5) had mothers with no chronic illness, 6) had mothers that suffered no hypertension, toxemia, or other complications during her pregnancy. The mothers were contacted by letter once it had been established that they fit our criteria. This contact was rapidly followed by a personal visit from a CDT who described the program in detail.

VISITATION PROGRAMS

Prenatal. During the first five home visits to the prenatal mother, much emphasis is placed upon the nutritional needs of pregnancy and lactation. In addition to

obtaining dietary information from the mother, the CDT also teaches the mother how to select an adequate diet from the Four Food Groups, makes her aware of bargains and smart shopping tactics, and, if necessary, shows her how to prepare food. The CDT discusses with the mother whether or not she will nurse the baby, and, when appropriate, helps plan an adequate diet for the mother during lactation. When necessary, emphasis on diet may continue throughout the three-month prenatal visit period. Dietary intake records taken for a 24-hour period each week are evaluated regularly by the nutritionist. These records help her to better advise the CDT's on necessary changes or additions to the pregnant woman's diet. It also gives a dietary profile for the last three months of the woman's pregnancy.

The cognitive needs of the infant are not stressed during the first few weeks of visitation. Instead, stress is placed upon the medical, emotional, and material needs of the mother and the new-born. Informal but intensive discussions of the developmental progress of infants during the first year of life also take place. During the last few weeks prior to the child's birth, the expectant mothers are shown early sensory experiences and vocalizing games in preparation for play with their expected children.

Birth to Six Months. Once the child is born, the CDT continues to supply the mother with information which deals with the emotional, cognitive, medical, and maternal needs of the child. She attempts to help the family understand what to expect of their new infant and begins the cognitive training of the child with the mother. Materials used by the CDT's for early cognitive stimulation include Gordon and Lally (1967) materials and the John Tracy Clinic (1968) materials. The progress of each child is discussed at weekly case conferences with the Home Visit Director. At these conferences additional materials and exercises are created for a specific child by his CDT and the Program Supervisor.

Six to 18 Months. During the weekly visits with the mothers of six-month-old babies the CDT's continue to provide the cognitive and nutritional experiences explained above. Each week activities are presented to the mother, and work sheets are left with her which explain how the activities can best be performed. Inexpensive educational toys are made by the mother and the CDT during some of the visits, and are left there with the mother for use during the week. A library of books for young children has been established and is used extensively. Each week the trainer takes a new book to the home and exchanges it for one she left the previous week.

At this time the children are also enrolled in the nursery school portion of the program on a half-day basis. The CDT then schedules her visits around the child's attendance in school. She also acts as the liaison between the school and the home. See Figure 1 for a description of some typical CDT's visits.

SUMMARIES OF THE HOME VISIT REPORT and the CASEWORK INTERVIEWS

Weekly Home Visit Report. At the time this analysis was begun, home visits were being conducted weekly with 65 mothers and their infants. Of this number, 45 were children who had entered the program at six months of age, and the other twenty were born to mothers who had been visited prenatally by the same trainer. The number of visits to each mother varied since children enter the program at different times during the year. Thus, 590 home visit records were analyzed comprising as many as 22 visits with one mother, and only two visits with another mother.

The original purpose of the weekly home visit report was to enable us to find out:

1. how the mother reacted to the CDT on a personal level.
2. how the mother seemed to react to the instructions and exercises that the CDT left with the mother.

3. how the mother seemed to be able to cope with the instructions that the CDT gave her, i.e., whether or not the mother could and would do the exercises while the trainer observed.

4. how many adults and children participated in the training.

5. how many interruptions occurred during the visit.

6. what materials such as books and educational toys seemed to be available for the child.

7. how the mother seemed to feel about the program and her role in it.

Insert Figure 1 about here

The questions that follow represent areas of observed behavior when we found some differentiation in behavior among subjects. The data reported under each question are summarizations of the responses recorded on many of the different items on the visit report. The complete Weekly Home Visit Report is found in Appendix A. It contains the frequency of responses to the various items.

What was the mother's reaction toward the CDT's visit?

During 90 per cent of the visits, the mothers greeted the CDT's warmly, were receptive to what the CDT's had to say, and were cooperative. For a short period of time only five mothers continued to be disinterested. They seemed merely to tolerate the CDT's visit. Even this attitude changed as the CDT made repeated visits. About 80 per cent of the mothers were interested, asked questions, and listened to what the trainers had to say. The visits conducted in an atmosphere of disinterest and boredom were conducted with only five mothers.

What was the mother's reaction when asked to do various exercises?

The majority of the mothers would do the exercises when asked to do so by the CDT's. Only three mothers refused to do the exercises at all. One of these mothers refused to do them consistently for the first 7 visits, but then began to do them

when she found that her child responded to her. The refusals of the other two mothers showed no pattern in consistency of occurrence.

Who was present during the visits?

The CDT's conducted most of their visits at a time when only the mother and child were present. There were some cases, however, when as many as four to seven adults were present in the room where the visit was taking place. Whenever there was an additional adult in the room, one of them was usually the maternal grandmother.

Often, there would also be additional children in the room. One CDT listed as many as seven other children present in the room at the time of the visit. Children would often interfere with the mother and baby and would attempt to take the materials which the CDT had brought for the mother's work with the infant. It was often necessary for the CDT to plan specific play activities for the other children.

Were children's books or educational toys present in the home?

During the visits to the homes, the CDT's would attempt to observe the presence or absence of such items. They found that 19 mothers appeared to have these materials available on their first visits and continued to have them available. Ten mothers had no books available when the visits began, but obtained books later. Eleven mothers did not have educational toys available when first visited, but obtained them later.

What was the climate in the home at the time of the visit?

During most of the visits the only activity in the room was the interaction between the mother, infant, and the CDT. Most of the visits were conducted without delays except for babies who might be asleep when the trainer arrived or who fell asleep shortly thereafter. In general, the visits were conducted with a minimal amount of interruptions.

CDT Casework Interviews. The information reported below summarizes weekly casework interviews between the CDT's and the Home Visit Program Director. These reports differ greatly from what was reported on the home visit reports. The reasons for these differences will be discussed at the end of this section.

When the home visit program first began, many of the mothers who were visited had no interest in having someone come into their homes once a week to help them learn how to train their children in cognitive skills. Although the demographic backgrounds of the mothers in our sample were similar as far as education, occupation, and income, their concepts of child-rearing and their interest in our program varied greatly. Some mothers, when recruited, were immediately interested in the program as a means of aiding their children and saw it as helping them achieve goals they had been unable to attain without assistance. Others were not interested in either the program or the CDT's. The latter group included many extremely young mothers who were still in high school and looked upon the Children's Center program as merely another way to relieve their own mothers of caretaking pressures. The mere mention of taking an hour a week so they could learn to be better mothers was repulsive to them. The CDT's were told to talk to a grandmother, a baby sitter, or another relative because the mothers "didn't have time for them." The CDT's, however, insisted that they would work only with the mothers.

The CDT's have changed their visiting times to evenings, Saturdays, and Sundays, if those are the only times the mother could be seen. CDT's have visited for two, three, or four hours at a time if a need for longer visits was felt by the CDT or expressed by the mother. CDT's have taken the mothers for clinic appointments, have waited in doctor's offices, and have helped ease problems with the welfare or probation offices. When a mother had a problem or was not participating in the program, the CDT often returned to the house many times during the week.

In interviewing the CDT's, a variety of living patterns were discovered. Many of the mothers were between the ages of 13 to 18. Some of them lived alone with their child, but the majority of them lived in larger, more complex units which included a variety of relatives. Most of these mothers are dependent on their families for financial support and on their mothers for emotional support and child care. It has become increasingly evident during this past year that a great deal of work and teaching needs to be done with the grandmothers as well as the mothers. We have found that the CDT's must find ways to work directly with the mother of the child which do not alienate the grandmothers. The methods and instructions given by the CDT's differ in many ways from the way the grandmother raised her children, and unless she is convinced that the newer methods are better, the mother of the child will never become fully involved in the program. When the grandmothers are convinced that this will help their daughters to become better mothers, the problems of involving the mothers in the program are not necessarily resolved, but they are lessened.

In many cases where the mother of the child was resistant to suggestions made by the CDT about the nutritional, emotional, maternal, and cognitive needs of the child, consultation with the grandmother often brought about the desired changes. This method of operation must be used sparingly, however, so that the mother does not perceive that the CDT and the grandmother are in collusion.

The interviews with the CDT's make clear the complexities of life and the multiple problems with which many of our mothers are faced. The interviews also make evident the need for the Center to broadly define its service role. The protocols of two mothers illustrate this point very well.

When one mother was first contacted, she readily agreed to allow her child to participate in the program. She had given birth to another child a year previously,

and saw her child's participation in the program as something that would ease her caretaking load. When the CDT arrived at the house on the first few visits, the mother would not answer the door. The CDT did not give up. She returned many times during the week at various hours, and slowly, by her persistence, understanding, and concern, gained the mother's confidence. This mother did not seem to conceive of herself as a mother at all. She was overwhelmed by motherhood and stated that the children were just "too much trouble." The CDT became almost a mother to this woman and she displayed an interest and a pride in the young mother's accomplishments. Eventually, the mother began to exude some pride and confidence in herself and she eagerly awaited the CDT's visit so that she could show the CDT what she had been teaching her child.

This mother's enthusiasm continued for some time, and her child attended the Center with some regularity. The Center's physician discovered that the child had a serious ear infection. On the physician's advice and through the constant prodding by the CDT, the mother took her daughter to a clinic. There, the ear infection was diagnosed and treated. When the ear infection had cleared, the baby made rapid advances in areas in which she had heretofore made little progress. It was found out that the ear infection had affected both the child's hearing and equilibrium, and this had probably slowed down her development. The mother's confidence in and enthusiasm about the Center was increased by this incident.

Then the mother's attitude changed drastically. She stopped working at home with her baby, and she became insolent and unpleasant to the CDT. The child's attendance at the Center became erratic. It was learned that the mother was pregnant again, and it seemed that she could not cope with a third pregnancy in less than three years. The mother's health deteriorated, and the father of the child left

the home. Along with these factors, the mother's house and attitude generally deteriorated, and the mother seemed to be in a state of general ennui. The CDT is presently searching for a home aide to relieve this mother from some of her home obligations and caretaking duties until the mother gives birth next month. The CDT feels that there is still hope for this mother's active re-entry into the program once the new baby is born and the mother's health has returned to a somewhat more balanced state. In the meantime, the CDT is continuing with the home visits, and is attempting to help the mother cope with the multitude of troubles which have beset her. By constantly being present, the CDT is also attempting to show this mother that there is still an element of constancy in her life.

The second protocol involves a mother who fully cooperated with the CDT at the beginning of the home visit work. The mother was always home and ready to do the activities when the CDT arrived. Suddenly, the mother moved into an apartment of her own and she became unavailable (the mother had previously been living in her mother's home). The mother continued to send her son to the Center, but she would not answer the door when the CDT called. The CDT would gain entrance only when she went with the Center's driver as he delivered the child to the home. When she did get into the home, the mother was unpleasant, and would not do the exercises, and she would barely listen to what the CDT was saying. After a few weeks of persistence on the part of the CDT, the mother revealed that she was pregnant again. The mother was very upset about this, and her confusion was compounded by the fact that her husband had been sent to prison seven months previously. The mother was concerned and worried about the reactions of people to her new pregnancy. Once the mother realized that the CDT would not place a judgment on her, the mother returned to being the same cooperative person she

had been in the beginning, and the CDT has had no further trouble in finding this mother at home. This CDT feels that whenever a mother becomes resistant and changes her behavior, there is good reason for it; if the CDT is patient, the reason will become apparent and then the trainer can help the mother ir dealing with her problems.

A Comparison of the Home Visit Reports and the CDT Casework Interview. In looking at the data received from the home visit reports in comparison with the CDT casework interviews, we feel that the home visit reports did not give a complete picture of the development of the program nor did they amply describe the involvement of the mother with either the program or her child. We found that we had received only a limited view of these relationships. The home visit reports seemed not to have been structured in a way that would differentiate between the minimal social graces most people would extend to a visitor in their home, and more basic feelings and actions. They did not portray the problems of establishing rapport, the difficulties in finding the mothers at home at the appointed hour, nor the time and effort required to get mothers to do the activities each week. A data collection method needs to be instituted which is sensitive to the relationship between the CDT and the mother, the mother and her child, and the mother and the center. If one only looked at the home visit report data one would be under the impression that we are dealing with an ideal population actively interested in the program, which listened without reservation to the CDT, and worked actively with their children from the very first visit. The following case history is an example of the discrepancy between the weekly home visit reports and the CDT case interviews.

One young mother entered her second child into the program when he was two months of age. He was to enter the day care center and the home visit program when he was six months old. When he came of age, the CDT arranged an entry date and a time for the child to be picked up by the driver. When the driver arrived, neither mother nor child appeared. The CDT went back later and was told that the mother had overslept, but would try to get up earlier the next day. It was two weeks before the baby finally entered the center. His attendance has always been poor since the mother continued to oversleep. When the CDT would come for her appointments, the mother would just be getting out of bed, even though the visits were scheduled for the afternoon. During each visit, the mother was as friendly and cooperative as she could be. She would listen to everything the CDT would say; she would agree with suggestions made; she would do the exercises which the trainer asked her to do; and she would "resolve" to do that which the CDT had advised. However, once the CDT had left the home, all was forgotten and neglected until the next visit. The CDT would come from each visit completely drained and discouraged, not from the attitude of the mother during the visit, but from the obvious neglect of the infant. The child would be left in the living room while the mother slept. When the CDT arrived the child was obviously unfed and unchanged, and showed signs of having cried for long periods of time.

Most of the mother's noninvolvement with her son and her lack of interest in changing was not recorded in the reports. During each visit this mother was very nice, listened "attentively," rarely had other adults in the home, and proceeded through the visit with few delays or interruptions.

The home visit record does not reflect the number of trips a CDT must make to a home before a visit can be completed, since it is only filled out at the end

of a completed visit or at the end of an entirely unsuccessful week. It does not show the array of reasons given to the CDT by other relatives or by the mother herself at a later time which excuse the mother's absence from the home at the appointed time. It also does not describe the bag of tricks used by the CDT's in order to just get into the homes. When one CDT did not get an answer to her knocks on repeated returns to a home where she was sure the mother was in, she went next door and used the phone. When the mother answered, the CDT told her she was next door and would be right over.

The home visit report does not record whether the mother has actually been doing the activity during the week. It merely tells the reader if the mother can remember them or if she has trouble understanding them. It does not record the development of the attachment between the mother and the child once the child begins to learn something directly through his mother's efforts. It is evident from interviews with the CDT's, that in the beginning many mothers consider their efforts to teach their child futile, until in one way or another the baby begins to respond.

One mother's disbelief in the purpose of the program and her resistance to efforts to demonstrate its effectiveness were so strong that it is difficult to understand why she consented to participate in the first place. She may not have understood the necessity for her full cooperation. On the first and second home visits she thought that the program was good for her, but would not do any of the activities with her daughter and thought that they would not do any good anyway. On the next four visits she became increasingly resistant and verbally expressed the fact that she didn't care for the program at all and thought the activities were nonsense. The CDT, however, continued to use various methods to try to interest her. She took added interest in an older son that the mother had considered backward and designed activities to do with him so the mother could observe his progress. The CDT took the mother

and her two children to a nearby park so they could have an hour or so of relaxation without "teaching." She spent other times with the mother just talking about anything the mother wanted to talk about. From these talks, the CDT discovered that the mother was experiencing a stressful separation and reunion with her husband, and was entertaining the idea of putting one or both of her children in foster home care. During the regular visits, the CDT continued to work with the study child doing the activities, in addition to explaining them to the mother, and attempting to get her to do them herself. The mother slowly began to see a change in her daughter. She also became aware that her daughter was doing things which her son had not been able to do at the same age. One day when the baby was resisting the efforts of the CDT, the CDT asked the mother if she would just try the activity with the child, since the daughter knew her better and would be more likely to respond to her efforts. Reluctantly, the mother tried it, and to her surprise her daughter immediately responded. From this point on, the mother's involvement in the program increased and she developed pride in her daughter's accomplishments. Within the next few visits the mother began reporting that she thought the program was "great." The problems with this mother and with her relationship to the program, to her daughter, and her older son have not completely disappeared, but they have lessened considerably. Once the child responds to the mother's teaching efforts, the mother's pride and confidence emerges. This has been reported repeatedly by the CDT's. The more the mother does, the more the baby responds, and the more the baby responds, the more the mother does. The CDT's have come to look for this interaction, since it seems to be a critical point for the involvement and interest of the mother in the program. It is unfortunate that this critical point of involvement is missing from the weekly report forms.

SUMMARIES OF THE NUTRITION QUESTIONNAIRE

Mothers' Eating Practices.

Two hundred forty dietary record forms have been completed for 31 prenatal and lactating subjects. Many of these clients have been visited by the CDT for three months with weekly food intake records. Intakes are evaluated each week in terms of food groups and afford a kind of dietary profile for the last three months of pregnancy, which the CDT uses for teaching the woman how to improve her diet. The intakes will be analyzed for specific nutrient content--particularly protein. The nutrient content in turn will be related to other parameters such as birth weight, length, and IQ.

We find that special diets, especially weight control and sodium restriction, are frequently recommended by the local clinics to our prenatal clients. Almost 65 per cent of the prenatal subjects were placed on special diets during their pregnancy and/or lactation. Over 48 per cent were placed on sodium-restricted diets, over 45 per cent on weight-control diets, and about 10 per cent on various other diets. Some women were placed on both weight control and low sodium diets. We find that these diets are poorly understood and rarely followed. When necessary, the nutritionist consults with the prenatal clinic about the dietary prescription and carefully instructs the CDT to help the client make the necessary modifications. If requested by the CDT, the nutritionist will visit the patient with the CDT to reinforce the teaching. Over 87 per cent of the women report taking some form of dietary supplement, but considerable confusion exists about whether the vitamin preparations contain iron or calcium supplementation.

Over 45 per cent of the women reported that they received donated foods (13 officially, and one from friends). The CDT's record the frequency of the use of

available donated foods and help the women to utilize infrequently used foods. Since over 33 per cent of the prenatal subjects reported that their meals were usually prepared by their mothers or other relative, the CDT's frequently had to advise other family members in how to best utilize donated foods and/or prepare special diets.

Thirteen of the prenatal subjects reported that they ate one or more of the following items: laundry starch, clay, seeds, unusually large amounts of ice (at least one tray a day) or other nonfood items. The reported frequencies are:

ice - 13 times by 8 subjects

seeds - 12 times by 5 subjects

laundry starch - 9 times by 5 subjects

clay - 1 time by 1 subject

baby powder and
other items - 2 times by 2 subjects

Infant Feeding Practices.

Included in this section of the paper are summaries of the answers to a nutrition questionnaire regarding infant feeding practices. Approximately 300 forms dealing with the diets of 73 infants were completed by eight Child Development Trainers during the period November 1969 to 1970. Data was reported at weekly intervals for the first month, and then monthly for the first year, except for the fourth month. The infants were divided into two groups according to their age at entry into the program.

Group I, group of expectant mothers selected in their sixth month of pregnancy was visited by the CDT's weekly for the remainder of their pregnancy. Nutrition and health education was a major part of the instruction during this period. Following the birth of the babies the CDT's continued to visit and instruct the mothers in a variety of areas centering around the emotional, intellectual, and

physical health of the infants. The 28 infants in Group I represent the babies born to the expectant mother group from November 1969 to May 1970. There was continuous entry into this group, as well as some cancelled appointments. These factors account for the differences in number of infants reported on at each age period from one week to three months.

Group II, group of mothers of five-and-one-half to six-month-old infants was recruited for participation in a program that included home visitation by CDT's as well as half-day attendance of their infants in the day care program at the Children's Center. Group II represents the 45 infants who entered this phase of the program between November 1969 and May 1970, and included data on infants at the various periods from 5 to 12 months. Table I contains the responses most frequently scored on the nutrition questionnaire at one month and seven months. These responses are representative of the responses scored at the other data collection times. The summaries that follow represent typical responses to the twenty-three item questionnaire and are presented to help describe the feeding habits of the program families.

Insert Table 1 about here

How much milk or formula was on hand for the baby?

Our first concern was to make sure that food was available to the infant. In almost all instances the CDT's reported at least a day's supply or more of milk or formula on hand for the infant. When this was not the case, the CDT checked to be sure that the mother had sufficient money or credit to purchase the milk or formula and could get to the store to do so. If this was not possible, the CDT found a way to get the mother some milk, even once or twice "borrowing" commercial formula from the Center.

Who usually feeds the baby?

Most of the mothers report feeding their babies most of the time, but there were a few babies who were fed primarily by a grandmother, father, other relative, or nonrelative. The request for feeding information in itself changed the habits of many mothers. The ability to give the CDT a 24-hour record of the infant's food intake helped make the mothers realize that it was good to know what foods the babies were fed when they were with a babysitter or with another caretaker. They were surprised to find out that their practices differed from those of some of the other people who took care of their child and used this new knowledge to better coordinate the child's diet.

How many times a day does the baby usually eat?

As would be predicted, the younger the infant, the more frequently he was fed. During their first three months most of the infants were fed every 3 to 4 hours, whereas by five months they were fed 3 to 4 times a day. Only the extremes of frequency of feeding were discouraged by the CDT's. Those mothers who fed their babies every 1 to 2 hours because the babies were awake or crying were encouraged to play with them, to do their cognitive exercises, or even to give them some water. The others were encouraged to space formula feeding 3 to 4 hours apart. At the opposite extreme a few mothers fed their babies less than three times a day, and they were urged to give at least four feedings to the infant. Eight of the ten infants who were twelve months old were fed three or four times a day.

Who told the mother what to feed the baby?

After their babies were two months old very few of the mothers said they followed the advice of any medical professional when it came to deciding what to feed the baby. Neither did they report accepting the paraprofessional's suggestions. By the time the infants were three months old at least half the mothers decided themselves what to feed the baby.

Was the baby ever breast-fed, and if breast-fed does the mother ever feed the baby any other kind of milk?

During the early home visits to the expectant mothers it soon became apparent that very few of the mothers planned to nurse their babies. This was clearly shown in the answers to these questions. Six of the 28 infants in Group I (21 per cent) were breast-fed; four for two weeks, one for one month, and one for two months. Only one of the breast-fed infants was not frequently given a supplementary formula. One 13-year-old mother reported nursing her baby only at night so that she did not have to get out of bed to feed him.

Six (13 per cent) of the mothers of the infants in Group II reported having breast-fed them--two each for one week, one month, and two months.

A decreased incidence of breast-feeding in the total population, as well as in the low-income groups has been observed by many investigators (Fomon 1967, Robertson 1961, Newsom and Newsom 1962, and Salber and Feinleib 1966).

What kind of milk or formula is the baby fed?

During the first week all of the infants in Group I were fed a commercial formula, even if they were being breast-fed. With the exception of one infant this also applied to the second week. During the first three-month period three infants received a home-made formula. Two of these formulas were made from evaporated whole milk, and one from evaporated skimmed milk. One infant was fed whole cow's milk from the age of one month.

By five months at least two-thirds of the infants were receiving regular whole milk. Infrequent use of evaporated whole milk was reported. This practice is similar to that reported by Fomon (1967). It is unfortunate that at this time we do not have overlapping time data from Group I and II so that we could understand when the change from commercial formula to whole cow's milk took place. Obviously commercial formulas were prescribed by the hospitals when the mothers were discharged regardless of their economic status.

With only two exceptions, one brand of commercial formula was used. The concentrated liquid form of the formula was usually used with an occasional use of the "ready-to-feed" type. The hospitals in this area have been part of a study sponsored by the company who produced this particular brand. Evidently this brand was the sample given at the time of hospital discharge and was automatically continued by the mothers. The cost varied from $.29 to $.39 per 13-ounce can for the concentrated liquid form, and from $.53 to $.65 per quart for the ready-to-feed can. At the same time, evaporated milk was available for $.18 to $.20 per can.

Except for the first week after leaving the hospital, most of the commercial formula fed to the infants did not contain iron supplement. Only six mothers reported feeding any other kind of milk or formula when the commercial formula was used.

How was the baby fed?

Most of the mothers who were feeding their infants solid food indicated that they were using a spoon to do so; however, the CDT's reported that a few mothers put solids--cereals, fruit, vegetables--into the infant's formula and punctured large holes in the nipples so that he would be able to suck it out. The mothers stated that with this method they were sure the infant got all the food and they found that it was less time-consuming.

The spoon appeared to be introduced during the first three months, and the cup during the last six months of the first year. All but one of the infants in Group II were still receiving at least one bottle per day at the end of their first year. CDT's did not discourage bottle feeding during this period as long as the mother was also offering the cup or glass to the child.

Where is the baby usually fed?

The data for the first three months indicate that all but two of the babies were usually fed while they were in someone's arms. Because some of our families did not

have a high chair, older children were frequently fed while sitting on the feeder's lap. Feeding time was emphasized by the CDT as an excellent opportunity to cuddle and love the baby, to talk to him, and to develop a closeness between mother and child. Propping a bottle in the crib was discouraged as a poor way to develop emotional ties as well as possibly being dangerous for the young infant who might choke.

What is the food (other than milk) which is usually fed to the child?

Although two infants were fed family food or commercial junior food during the second month, most of the infants did not receive these foods until after the fifth month. At this time the transition from milk and formula appeared to be to regular family foods as well as to commercial junior food. From eight months of age, approximately one-third of the infants were receiving only food from the family table, and in relatively few cases was it indicated that this food had any special treatment such as mashing or straining. It was not unusual for a mother of a six- or seven-month-old to report feeding the infant chunks or slices of meat.

The CDT's encouraged the mothers to fix appropriate food in a manner that the various aged infants could handle, but it seemed extremely important to many of our mothers to have their infants on "adult food" as soon as possible. When we have an opportunity to analyze the dietary intake records for this group, we predict, as others have found (Ho and Brown 1970, Beal 1957), a reduction in calories and other nutrients somewhere between the 4th and 6th month. This reduction in nutrients will continue until the infants adjust to the flavor and are able to bite, chew, and swallow sufficient quantities of the "new" diet. One might raise the question of what is gained from the early introduction of solids if this decrease occurs. This decrease is especially true as far as iron requirements are supplied, hence plans are being made to compare hemoglobin levels of the infants when they enter the Center at six months, and again at nine and 12 months.

How often does the baby eat various foods?

As reported by other investigators (Butler and Wolman 1954; Filer and Martinez 1964) solid foods were introduced to the infants at a very early age. By three weeks almost half of the infants were being fed cereal and a third of them were also getting fruit. Since this practice was not encouraged by the CDT's and had not been recommended by a physician (it was usually at least six weeks after birth before the infants were taken to clinics), the decision to do this was probably made by the mother. Guthrie (1968) lists several reasons mothers give for the early introduction of solids. Some of these reasons are so that the baby will: sleep through the night, grow faster, and avoid anemia in later childhood. She also points out, however, the scarcity of experimental evidence to support any of these theories.

Vegetables and meats followed cereal and fruits into the diets of the infants, and by six months approximately 90 per cent of the babies were receiving cereal, fruit, vegetables, and meat. Since most of the foods introduced during the first six months were commercial baby foods with relatively high sodium content, it is important to gain a better understanding of the relationship of high sodium intakes and hypertension (Guthrie 1968, Dahl 1968).

By six months, breads, crackers, cookies, eggs, combination dishes, ice cream, puddings, cakes, pies and candy were being fed to more than half of the infants. Nuts were not being used as infant food. Boiled water was fed to infants under three months, but not to any extent after five months. Most of the infants were not given fruit juice until 5 months of age. At this time they were also fed soft drinks, sugar water, and Kool Aid. Beer, wine, and whiskey were occasionally fed to a small number of infants after five months.

With one exception (catnip to a three-week-old), no nonfood items were reported consumed by any of the infants under four months. The older infants (5-12 months)

consumed many nonfood items. Paper was eaten fifty-five times (by 20 children frequently). Other items eaten were: wood (11 times), clay and dirt (nine times), seeds (six times), and starch (two times). Additional items such as cigarette butts, ashes, dust, and the catnip were also reported eaten by the infants.

Does the mother add any salt to the baby's food?

Although none of the mothers of infants under four months reported adding salt to the baby's food, the fact that the infants were fed commercial baby food which had sodium added to the processing would indicate that the infants' diets were high in this element. Mothers of the older infants reported adding salt more frequently to the infants' diets, and between 30 and 40 per cent of those infants over six months had salt added to whatever was already in the commercial baby food or what was used in the preparation of regular family food. As previously suggested, if this is a problem in later hypertension (Guthrie 1968, Dahl 1968), mothers need to be made more aware of the possible harmful effects of this practice.

Summary of Nutrition Section

At the time of this analysis, 300 forms acquired from mothers of 73 infants were summarized. Twenty-eight of the babies were born to prenatal mothers, while forty-five were children who entered the program at six months of age. The obtaining of a 24-hour food intake record from the mothers helped to make them aware of the food her child was eating. The majority of babies in the program were bottle-fed babies; twelve mothers reported that they had breast-fed their infants, with nine of these stopping at one month. With only two exceptions, one brand of commercial formula was used throughout the period of formula feeding. Most of the infants did not receive family food or junior foods until after the fifth month. At this time the transition appeared to be mainly to regular family food. Very few mothers said they followed the advice of any medical professional after their child reached his second month of life. At least half of the mothers reported that they decided what to feed their babies.

The spoon appeared to be introduced during the child's first three months, and the cup during the last six months of the first year. The introduction of solid foods usually came at a very young age and usually without the advice of a physician. By three weeks almost half of the infants were being fed cereal, and a third of them were also getting fruit. Vegetables and meats followed in sequence, and by six months approximately 90 per cent of the babies were receiving all of these foods. By six months of age, breads, crackers, cookies, eggs, combination dishes, ice cream, puddings, cakes, pies, and candy were being fed to more than half of the infants. It was suggested that early intake of salt and later problems of hypertension be studied.

IMPLICATIONS AND CONCLUSIONS

Our experiences in the past months have made it evident that any program that presumes to care for the needs of multi-problem families must be extremely sensitive to the basic problems facing these families. Just to keep from suicide and other less obvious forms of self-destruction is a credit to the strength and resiliency of the families. The economic exploitation, the legitimate fears of daily harm, the constant affronts to their dignity, and the witnessing of brothers and sisters, sons and daughters, moving to drug addiction and lives of crime are ever present, but still they survive and try to make life better for their infants. We have learned that problems change daily, and that those that are seemingly solved for awhile can return with even greater intensity. It would be presumptuous to claim that the CDT home visit program was an unqualified success. We do feel, however, that it is a positive approach to helping people begin to solve some of their daily problems. We also feel that the CDT has done this in a way which does not destroy family pride, but actually increases it.

The basic assumption we made that each of the families visited wants everything possible for their child, and that they are willing to provide it if they know what needs to be done, may seem to be confirmed after reading the two protocols included herein. These protocols serve to show that once the mother's confidence in the CDT and the program was gained, the mothers cooperated and even initiated requests for special training or information. The problem of initial rapport between the mother and the CDT was anticipated, was dealt with by the CDT's, and through their constant efforts and presence they have overcome this problem. This is something hard to quantify, yet is something which can be reported anecdotally by the CDT's.

One compelling problem which faces us is a much needed revision of the home visit report. As stated before, this record needs to show the number of attempts needed to reach the mother, the excuses given (by the mother or others) for the mother's absence, the mother's and child's performance regarding the exercises she does with her child, problems encountered during the week by the family, length of the visit--in short, information which will give us a better portrayal of the visit, and information which can be used by the CDT in planning future visits for the family. The home visit report must be made more sensitive to the actions of the families and the infant in order that we may have a clearer picture of what went on during the visit, or it should be abandoned. In addition, a scheme must be developed which would describe the mother's involvement with her child as she goes through the activities with him,and her own commitment to having the child perform in a desired and appropriate manner. Although the CDT's are trained to work with the mothers and children and are not primarily data collectors, the direct observational method would be most apposite to describe the mother's involvement. This procedure, however, may be an affront to the mothers, and will probably not be used.

A second important point to which the program must be aimed is to involve, wherever possible and applicable, the grandmothers of the children, because many of the mothers enrolled in the program live with their own families and are highly dependent upon them. We have found that many of the mothers resisted the CDT's suggestions and would comply with them only after the grandmother had given approval. What must be done is to involve the grandmothers in the CDT's activities with the mother and child, perhaps through simultaneous visits with the grandmother and mother. Perhaps we would gain more information concerning the child from the grandmother, and devise new ways to present activities to the child and to work with the mother.

A third point of future direction is to increase the mother's commitment to her child's cognitive development and progress through more fully involving the mother in the active running affairs of the Center's program. During the past year many of the mothers visited the Center before their child started in the day care program, and sometimes before the infant's birth. They were introduced to those who would be involved with the care of their infants. The CDT's reported that these visits have made the mothers feel more comfortable about what happens to their child when he is away from the home, and in some cases these visits have served to increase the mother's interest in her own activities with her child in the home. The visits to the Center have served as feedback to the mothers in that they see replicated many of the home exercises which they perform with their children. Plans are now underway to have the mothers take a more active part in the actual planning of Center activities, and to have them participate in classroom activities. It is hoped that the Center will become a "real" part of their lives, and that the Center will exhibit and extend the cultural aspects of the children's neighborhoods rather than ignoring them.

Implications from the data reported here suggest that a continued effort must be made by the CDT's to instruct the mothers in their own dietary practices as well as those of their children. This must be started prenatally and stress be placed on the new infant's diet for as long as six months after delivery.

The CDT's must also continue to stress the early sensory, emotional, and cognitive needs of young children. The CDT's need to have the mothers understand why these are important, how they as mothers can help to meet these needs, and how the exercises we give them are instrumental to their child's development.

Although this program is designed for infants who are first or second born, it was found this past year that problems do arise with other siblings and the mothers' attitudes towards them and the program when the sibling is not involved. The CDT's have found some mothers expressing guilt at not being able to give their other child the same advantages as the study child, or conversely, to degrade an older child because he is not as "smart" as the study child. It is hoped that activities for other ages can be devised and demonstrated for use with older children. This would allow the mother to work with both children on an equal basis, and would increase her awareness of the necessity of her involvement in the cognitive progress of her children.

TABLE 1

Responses Most Frequently Scored at 1 Month and 7 Months on the Nutrition Question

estionnaire item	Group I: 1 month N=25		Group II: 7 months N=20	
	Most frequent response	Percentage of total responses to the item	Most frequent response	Percentage of total responses to the item
ɪlk or formula on hand for the baby:	Enough for a day's feeding	52	Enough for more than a day	40
ıo usually feeds the baby?	Mother	92	Mother	55
ɔw many times does the baby usually eat?	Six times a day	36		35
ıo told mother what to feed baby?	Doctor	68	Decided herself	60
ʃ breast fed, does baby feed on any ɔher milk?	Frequently	100	No breastfeeding No data	
ıat type of formula is baby being fed?	Commercial formula	92	Plain milk	80
ɔw is the baby fed?	Bottle and spoon	48	Unknown	40
ıere is baby usually fed?	Someone's arm	96	Someone's arm	50
ɔod (other than milk) usually fed:	Commerical strained baby foods		Family and commercial, baby and junior	40
ɔes mother add salt to baby's food?	Occasionally		Occasionally	60
ıat brand of commercial formula is used?	Enfamil	88	Not applicable	90
hat form of commercial formula is used?	Concentrated liquid	86	Not applicable	90
s there iron in the commercial formula?	No	56	Not applicable	92
as the baby ever breast fed?	No	84	No	92
ʃ plain or homemade formula what kind of ɪlk is being used?	Not applicable	92	Whole milk	70
s baby on any special diet?	None	100	None	100

Table 1 (cont.)

uestionnaire item	Group 1: 1 month N=25 Most frequent response	Percentage of total responses to the item	Group II: 7 months N=20 Most frequent response	Percentage of total responses to the item
ow often does the baby eat the following oods:				
Cereal	Frequently - every day or two	52	Frequently	65
Fruit	Never	72	Frequently	65
Vegetables	Never	92	Frequently	75
Meat, fish, poultry or cheese	Never	100	Frequently	60
Bread, crackers, cookies	Never	100	Frequently	70
Eggs	Never	100	Occasionally - 1 or 2 times a week	45
Combination dishes	Never	100	Frequently	45
Ice Cream	Never	100	Occasionally	35
Boiled water	Frequently	52	Never	75
Soft drink, sugar water, kool aid	Never	96	Frequently	45
Fruit juices	Never	82	Occasionally	
Paper			10 times	
Beer, wine, whiskey	Never	100	Never	75
Laundry starch	Never	100	Never	100
Wood	Never		Two cases	
Clay and dirt	Never		Never	
Other non-food	Never	100	Occasionally	60

Figure 1

Some Typical CDT Visits

First visit after baby is born:

1. CDT sees the baby and asks the mother if she had any problems during the first few days at home with the infant.

2. CDT talks to the baby while emphasizing to the mother the importance of her doing the same.

3. CDT discusses the mother's health care arrangements for the baby and stresses the importance of regular health care.

4. The CDT proceeds to take a diet record for both the mother and the infant.

5. The CDT presents a few cognitive activities and discusses what the baby will begin to do in the next month or so. She emphasizes the importance of early sense experiences for the infant.

6. The CDT ends the visit informally talking about things which the mother considers important.

3 Months

1. The CDT asks the mother if any problems have arisen during the week.

2. The CDT completes a diet record on the infant and discusses any recommendations which the nutritionist may have made concerning the baby's feeding.

3. The CDT asks the mother about the baby's progress with the cognitive activities and asks her to demonstrate the baby's progress.

4. If the baby seems to be progressing and learning the task already assigned, the CDT demonstrates a new task. The CDT will usually have the mother read the instructions and then asks if there are any questions concerning the manner in which the task is to be done. If the child has not learned the previous exercise, the CDT may ask the mother to continue what she has been doing, or show her ways to make the activity more appropriate to the child's point of development and interest.

6 Months

A. When a child has not previously been visited by a CDT.

1. The CDT introduces herself and begins her conversations with a detailed description of the program. She answers any questions which the mother might have and tries to show the mother that she respects her and wants to be her friend.

2. A diet record is taken by the CDT on the baby. A discussion of diet information on young children follows.

3. The CDT demonstrates and discusses the cognitive activities that the baby will be doing in the next few months and describes the necessity for doing these activities regularly. Emphasis is placed on the necessity for talking to the infant as often as possible and expecting a vocal response.

4. The CDT demonstrates an activity with the infant and asks the mother to try it. In many cases the mother is reluctant to try, so the trainer will ask her to do them during the week, and perhaps by the next time she will feel more confident.

5. The CDT ends the visit informally talking about things which the mother considers important.

B. When the child has been in the program since birth.

This visit is similar to the three-month visit presented earlier, except that the activities become developmentally more sophisticated, and as time proceeds, the CDT does less and less herself with the baby, and relies on the mother to do the work. The only time the CDT might work with the infant is when the mother has a problem understanding the exact procedure she should follow in doing the activity. This procedure is used so that the mother understands that it is her work with the infant that is important and that the CDT is just helping her to become more proficient.

APPENDIX A

PARENT EDUCATOR WEEKLY HOME VISIT REPORT

Mother's Name:_____ Child's Name:_____

Child Development Trainer:_____

Col. 25 The visit was

560 1 - Successfully made; mother was at home.
28 2 - Mother was not at home, but visited with someone.
0 3 - No one was at home: visit not made.
0 4 - Someone was at home, but no visit made.

If you answered (3) three or (4) four, STOP HERE! Now go to Col. 68 on the last page and finish the report. Skip items 26-67. It is not necessary to code everything zero.

Col. 26 The mothering one

535 1 - was warm, receptive, cooperative.
22 2 - worked with (tolerated) parent educator.
30 3 - showed little concern.
0 4 - made fun of parent educator's ideas.
0 5 - was openly hostile to parent educator's ideas.

Col. 27 The visit was

472 1 - not delayed.
7 2 - delayed due to care of children.
6 3 - delayed due to housework.
10 4 - delayed due to eating.
12 5 - delayed due to talking with friends or relatives.
5 6 - delayed due to getting dressed.
40 7 - delayed due to sleeping child.
34 8 - delayed due to other reasons.

Col. 28 Today's visit was with

553 1 - a mother who normally cares for child most of the time.
15 2 - a mother who does not normally care for the child (probably not paid).
17 3 - someone else who normally cares for the child most of the time (probably paid).
1 4 - temporary babysitter -- someone who does not normally care for the child most of the time (probably paid).

25	26	27	28

Note.--These frequencies are based on 590 home visits involving 65 mothers.

Col. 29 How much activity was in the room in which you presented the exercises?

387 1 - Nothing was going on besides the training_____.
80 2 - Other activities were going on but did not attract the attention of the baby _____.
82 3 - Other activities in the room often pulled the baby's attention away from the training._____.
27 4 - There was such a great deal of activity in the room that it made it difficult to present the exercises_____.

Col. 30 How many interruptions were there during the task training period?

351 1 - None
165 2 - One or two
31 3 - Three or four
31 4 - There were almost always distractions in the room.

Col. 31 What was the most frequent or longest interruptions?

335 1 - There were no interruptions.
72 2 - Mothering one had to care for another child.
26 3 - An adult wanted something.
25 4 - The phone rang .
45 5 - Visitors came
15 6 - The child had to be fed.
33 7 - The child went to sleep.
23 8 - A distracting TV show, record player, or radio.

Col. 32 During the visit the "mothering one" was

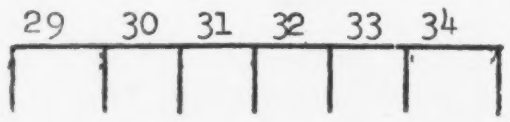
464 1 - present all of the time.
92 2 - present most of the time.
21 3 - present part of the time.
8 4 - not present.

Col. 33 During the visit the father was

9 1 - present all of the time.
1 2 - present most of the time.
17 3 - present part of the time.
122 4 - not present.
435 9 - no father in this household.

Col. 34 During the visit the father was

8 1 - interested in the training and wanted help.
26 2 - interested but did not take an active part.
3 3 - not interested but did not interrupt the training.
0 4 - not interested and interrupted the training for something trivial.
0 5 - openly hostile against the training and tried to disrupt and/or discredit it.
1 6 - thought the training was foolish but did not bother it.
534 9 - not applicable (no father present).



Col. 35 How many adults were in the room during the visit other than you and the mothering one?

114	1 - one	15	4 - four	0	7 - seven
38	2 - two	4	5 - five	4	8 - more than seven
32	3 - three	0	6 - six	370	9 - no adults present other than the PE and the mothering one.

Col. 36 How many children were in the room during the visit (Count the child you are working with as one if the child was there).

284	1 - one	19	4 - four	1	7 - seven
125	2 - two	4	5 - five	0	8 - more than seven
45	3 - three	2	6 - six	99	9 - no children present

Cols. 37-42 Which tasks were presented today? Place the series number in columns 37 and 38 and the exercise number in column 39. For example, if you worked with Series XII-4, this would be coded as 12-4.

37	38	39	40	41	42
1	2	4	1	2	5
Series		Ex.	Series		Ex.

Do the same in columns 40, 41 and 42, if a second task was presented; if not, enter zeros.

Col. 42 How did the mothering one react to your instructions?

480	1 - Looked at you while you were talking. Asked questions; was attentive.
39	2 - Did other things while you were showing her how to do the task (ex: straightened child's clothes, looked around the room, did housework) listened passively.
4	3 - Walked out of the room while you were explaining things to her.
6	4 - Refused to do task.
0	5 - Laughed at and/or scoffed at instructions.
9	6 - Embarrassed or shy in performing before parent educator.
13	7 - Did not instruct mother on any particular task.

Col. 44 Mothering one's ability to repeat the tasks you presented today.

403	1 - Could repeat tasks you had explained to her.
54	2 - Could do part of the tasks by herself, but needed the trainer's help.
5	3 - Could not repeat tasks you had explained to her.
9	4 - Embarrassed or shy in performing before parent educator.
10	5 - Refused to try the task.
55	6 - Did not ask her to repeat tasks because none were presented.

Cols. 45-47 Which tasks were presented on your last visit?

Cols. 48-50. Place the series and exercise number in the proper columns as shown in Col. 37-39. If this week's visit had a repeated exercise, it should still be recorded here.

35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50
		Series		Ex.	Series		Ex.			Series		Ex.	Series		Ex.

Col. 51 Mothering one feels that on last week's tasks the child was:

205 1 - highly interested and successful.
35 2 - highly interested but could not handle materials.
144 3 - mildly interested and successful.
33 4 - mildly interested but could not handle materials.
25 5 - little interested but could handle materials when urged to.
42 6 - little interested but was not able to handle materials.
35 7 - not applicable (new child in project).
50 8 - did not go over or discuss last week's task.

Col. 52 When the mothering one goes over last week's tasks with her child, she:

15 1 - doesn't know what she is doing.
426 2 - knows what she is doing.
35 3 - not applicable (new child in the project).
97 4 - did not go over last week's tasks (or there was no task or visit last week).

Col. 53 When the mothering one goes over last week's tasks with her child, she:

56 1 - gets discouraged if child doesn't do task the first time.
101 2 - is satisfied even if child doesn't do well.
186 3 - tries again even if child doesn't do well the first time.
77 4 - tries until child can do it or child gives up.
21 5 - continuing task even after child does well.
134 6 - did not go over last week's task.

Col. 54 Did the mothering one say the child was sick?

93 1 - she said the child was sick.
311 2 - she said the child was not sick.
164 3 - she did not say whether the child was sick or not.

If the mothering one said the child was sick, explain:

_____

_____

Col. 55 Did you think the child was sick?

84 1 - Yes 467 2 - No

Explain if you have a different idea than the mothering one:

_____

_____

51	52	53	54	55

Col. 56 Community services information or child growth and development information was presented to the mothering one by the parent educator.

78 1 - Yes_____ 480 2 - No_____

Col. 57 Referral was made (you notified the nursing or other group to get help for the parent).

45 1 - Yes_____ 509 2 - No_____

Col. 58 Songs. nursery rhymes. toy making. rhythm games. or other enrichment materials were presented to the mothering one by the parent educator.

317 1 - Yes_____ 237 2 - No_____

The Child Development Trainer observed in the home:

Col. 59	Books	307	1 - Yes_____	237	2 - No_____
Col. 60	Magazines	277	1 - Yes_____	249	2 - No_____
Col. 61	Educational Toys	352	1 - Yes_____	182	2 - No_____

Col. 62 How was the child generally treated by the mothering one:

123 1 - The child always seems to get its way.
63 2 - The mothering one treats the child as if the child were always in the way.
1 3 - The mothering one often scolds, ridicules, shames or punishes physically the child.
4 4 - Both 2 and 3, above.
296 5 - The mothering one listens to the child, compliments the child' the mothering one and the child seem to really enjoy each other.
69 6 - The child was not present.

Col. 63 To what extent do people talk to the child?

254 1 - The child is talked to often, with long descriptions of everything going on.
183 2 - The child is talked to sometimes. but not regularly.
17 3 - The child is only talked to when someone is giving an order.
46 4 - No one talks to the child much.
68 5 - The child was not present.

Col. 64 When the mothering one gives an order to any of the children present, she:

144 1 - requests child to do something, giving reason
17 2 - requests child to do something, giving no reason
4 3 - requests child to do something, with threat.
22 4 - orders child to do something, giving reason.
17 5 - orders child to do something, giving no reason.
8 6 - orders child to do something, with threat.
353 7 - not applicable (no orders given; no children present; etc.)

56	57	58	59	60	61	62	63	64

Col. 65 If the child makes gestures and/or sounds (not words) to show that he wants something or wants to do something, the mothering one typically.

237 1 - Responds by doing something for child.
114 2 - Responds with words.
13 3 - Ignores child.
0 4 - Scolds or criticizes child for not asking clearly.
1 5 - Pushes child away, etc.
199 6 - No request was made by child in this manner.

Col. 66 When the child asks a question, the mothering one typically

2 1 - Gives child a long, detailed, involved answer.
45 2 - Gives child a short but complete, good answer.
6 3 - Gives child a "get out of my hair" answer.
1 4 - Ignores or "brushes off" child.
502 5 - Child dod not ask a question.

Col. 67 When you see the mothering one, what is her attitude toward the project?

372 1 - She thinks the project is great.
108 2 - She thinks it is just OK.
81 3 - She doesn't say much about it.
7 4 - She doesn't seem to care much for the project.

67 68

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